PROTECTION OF RIGHT TO LIFE & HEALTH OF NON SMOKERS VIS A VIS ENFORCEMENT OF SMOKE FREE RULES

A Synopsis

Submitted to

MODY UNIVERSITY
LAKSHMANGARH • RAJASTHAN

COLLEGE OF LAW AND GOVERNANCE,

MODY UNIVERSITY OF SCIENCE AND TECHNOLOGY

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN LAW

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Introduction

Tobacco is not for the body, neither for the belly, and is not good for man, but is an herb for bruises and all sick cattle, to be used with judgment and skill.[1]

Tobacco smoking causes a wide-range of diseases and adverse health impacts that affect nearly every organ of the body. The smoke from a smokers' Beedi, Cigarette and other smoking forms called Second Hand Smoke (SHS) also causes serious health problems to those exposed to it.[2]

Tobacco use is a global epidemic that kills 5.4 million people annually, tragically, more than 80% of those deaths occurs in the developing world[3] . Nearly two in five (38%) adults in rural areas and one in four (25%) adults in urban areas use tobacco in some form.[4] Considering the enormity of the problem, member nations of the WHO negotiated and adopted the first public health treaty – the Framework Convention on Tobacco Control (FCTC) – in 2003. India was the eighth country to ratify the treaty that gives a vital opportunity to reduce the global burden of tobacco.[5]

Globally, about one third of adults are regularly exposed to SHS. Worldwide exposure to SHS causes nearly 603,000 premature deaths of non-smokers. [6] More than 39% of smokers and 40% of smokeless tobacco users initiated tobacco use before the age of 17 years [7] when they were far too young to understand the risks of tobacco use like addiction or to resist social expectations.[8]

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[1] The Bible, Section 89 (8)

[2] Guideline for implementation Smoke free rules (Section 4) and tobacco free Educational Institutions (Section 6) of COTPA 2003, A ready Reckoner for District and sub- district Law Implementer, Tobacco Control Cell, Ministry of Health and Welfare, Punjab http://pbhealth.gov.in/GUIDELINES%20FOR%20IMPLEMENTATION%20OF%20COTPA.pdf (accessed on 08 Aug 2015)

[3] World Health Organization. *WHO report on the global tobacco epidemic, 2008. The MPOWER package.* Geneva, 2008, pg. 1. http://www.who.int/tobacco/mpower/en/ (accessed on 08 Aug 2015)

[4] Government of India. Ministry of Health & Family Welfare, Global Adult Tobacco Survey, India, 2010.

[5] Implementation on Framework Convention on tobacco Control (FCTC) in India- A shadow report- 2010 http://hriday-shan.org/wp-content/uploads/publications/SHADOW_REPORT_COTPA.pdf (accessed on 08 Aug 2015)

[6] Oberg M, Jaakkola MS, Woodward A, Peruga A, Pruss-Ustun A. Worldwide burden of disease from exposure to secondhand smoke: a retrospective analysis of data from 192 countries. Lancet 2010.

[7] Global Adult Tobacco Survey Report 2010

[8] Supra note 2

In India around 900 thousand people die from diseases caused by smoking every year. This figure will rise to more than one million people every year by 2013. For every thousand 20-year-old smokers it is estimated that while one will be murdered and six will die in motor accidents, 250 will die in middle age from smoking, and 250 will die in older age from smoking.[9] In spite of the fact, Everyday more than 5,500 children start tobacco use in India.[10]

Effective comprehensive tobacco control laws that can impact reduced consumption are needed. Tobacco legislation in India dates back to 1975 when the Cigarettes (Regulation of Production, Supply, and Distribution) Act, was enacted, which made it mandatory to display a statutory health warning on all packages and advertisements of cigarettes. The Cigarettes Act, 1975, failed to accomplish much because it was not comprehensive in its coverage and was feeble in its provisions.[11] This was followed by a new legislation, the cigarettes and other tobacco products act (prohibition of advertisement and regulation of trade and commerce, production, supply, and distribution) 2003 (COTPA), which is the principal law governing tobacco control in India, being more comprehensive covering all tobacco products, including cigarettes for the control of tobacco.[12] The above law is intended to protect and improve public health, by making provisions of evidence-based strategies under the law to reduce tobacco consumption.[13] The Act was passed before India became signatory to the World Health Organization (WHO) Framework Convention on Tobacco Control on February 5, 2004.

Cigarettes and other Tobacco Products Act, 2003 (COTPA) is the principal law governing tobacco control in India. It is an Act which prohibits the advertisement of, and to provide for the regulation of trade and commerce in, and production, supply and distribution of, cigarettes and other tobacco products and for matters connected therewith or incidental thereto.

The largest impact of tobacco related disease burden is increasingly affecting the low-middle-income countries like India where each year tobacco use kills about one million Indians and where it remains a serious public health challenge not only resulting in substantial disability,

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[9] http://www.secondhandsmokekills.in/smokefree/costofsmoking.html
[10] Indian J Pediatr 1999; 66 : 817-824
[11] Reddy KS, Gupta PC. Report on Tobacco Control in India. New Delhi: Ministry of Health and Family Welfare, Government of India; 2004.
[12] Ministry of Law, Government of India, the Cigarettes and Other Tobacco Products (Prohibition of advertisement and regulation of trade and commerce, production, supply and distribution) Bill, 2003 (as passed by the Houses of Parliament), Bill No. XXIX-F of 2001 (G: \WIN1\BILL2000\LS\793 LS).
[13] *Supra note* 11

disease and death, but also increasing the social and economic costs of health care in limited health resource settings.[14]

Effective tobacco control is dependent on balanced implementation of demand and supply reduction strategies by the Government and inter sectoral coordination involving stakeholder departments and ministries.[15]

The term Public place is defined under Section 2 (l) of COTPA, 2003. It defines as "Any place to which the public have access, whether as of right or not, and includes Auditorium, Hospital Buildings, Railways Waiting Room, Amusement Centres, Restaurants, Public Offices , Court Buildings, Educational Institutions, Libraries, Public Conveyances, and the like which are visited by general public but does not include any open space. Open spaces under the Act shall not include any place visited by the public such as open Auditoriums, Stadiums, Railway Stations, Bus Stops/Stand and such other places. Public places shall also include Workplaces, Shopping Malls and Cinema Halls."

Statement of Problem

a. Whether there are enough laws in India to make the country 100 % smoke-free?

b. Whether there is proper and effective implementation of the law of banning the public smoking in the state of Rajasthan?

c. Whether the people aware about the effects of smoking on non- smokers which ultimately curb their right to live in free air enshrined under Article 21 of Constitution of India?

d. Whether the people aware about the laws and enforcement agencies for the control of tobacco causing smoke?

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[14] Jha P, Jacob B, Gajalakshmi V, Gupta PC, Dhingra N, Kumar R, *et al.* A nationally representative case-control study of smoking and death in India. N Engl J Med 2008;358:1137-47.

[15] Guidelines for Law Enforcers for effective implementation of Tobacco Control Laws 2013, MINISTRY OF HEALTH & FAMILY WELFARE GOVERNMENT OF INDIA http://www.searo.who.int/india/tobacco/guidelines_law_enforcers_implementation_tobacco_control_law.pdf?ua=1

Literature Review

In South East Asia, Bhutan (2004), Thailand (2006) and India (2008) are some of the countries that have successfully enforced a smoking ban in public places. Bhutan is the first country in the world to impose a total ban on tobacco products—sale and use.[16] China introduced a smoking ban in public buildings in Beijing from May 2008 as a run-up to the Olympic Games[17] and a ban on smoking in public places came into effect from 1st May 2011. Singapore has had smoke-free legislation since 1970, but has strengthened it recently.[18] Hong Kong enacted the smoking ban law in 1982 but could enforce it only since 2007.[19] Countries like Indonesia (2006), Kazakhstan 2003), Malaysia (2004), Bangladesh (2006), Pakistan (2003), Philippines (2002), Vietnam (2005), Brunei Darussalam (1988) have banned smoking in public places, but implementation is far from complete.[20][21]

The smoke from a smokers' Beedi, Cigarette and other smoking forms called Second Hand Smoke (SHS) also causes serious health problems to those exposed to it.[22] Secondhand smoke also known as involuntary smoking, environmental tobacco smoke, and passive smoking. "Environmental tobacco smoke is known to be a human carcinogen based on sufficient evidence of carcinogenicity from studies in humans that indicate a causal relationship between passive exposure to tobacco smoke and lung cancer. Many epidemiological studies, including large population based case-control studies, have demonstrated increased risks for developing lung cancer following prolonged exposure to environmental tobacco smoke."[23]

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[16] Global map of smoke free policies; prepared for the Global Smoke free Partnership, Gillian Griffith, April 2008

[17] Smoking Curbs: The Global Picture. Available from: http:// news.bbc.co.uk/2/hi/3758707.stm.

[18] Unfiltered: Conflict over tobacco policy and public health. Feldman EA, Bayer R, editors. Massachusetts: Harvard University Press; 2004. p. 394.

[19] List of Smoking Bans. Available from: http://en.wikipedia. org/wiki/List of smoking bans

[20] World Health Organization(WHO). Fresh and alive: MPOWER, WHO Report on The Global Tobacco Epidemic, Geneva, Switzerland: 2008

[21] Kaur J and Jain DC: Tobacco Control Policies in India, Indian Journal of Public Health, Volume 55, Issue 3, July-September, 2011 http://www.ijph.in/temp/IndianJPublicHealth553220-4811359_132153.pdf (August 08, 2015)

[22] Supra note 2

[23] http://www.secondhandsmokekills.in/pdf/second_hand_smoke.pdf

SHS has more than 7000 different chemicals, 69 carcinogens of which are known to be associated with causing Cancer.[24]. These chemicals are released into the air as particles and gases. The particulate phase of cigarette smoke include nicotine, "tar" (itself composed of many chemicals), benzene and benzo(a)pyrene. The gas phase includes carbon monoxide, ammonia, dimethylnitrosamine, formaldehyde, hydrogen cyanide and acrolein.

In India, smoking tobacco accounts for nearly one million premature adult deaths every year which is about 10% of all deaths at all ages. There are many reasons to ban smoking through smoke-free interventions. First, the ban on smoking in public places is a provision under current law, and is widely supported by the public and local implementers. Second, smoke free public places reduce exposure to SHS and help to "denormalise" (reduce social acceptance) of smoking in public places. Third, smoke free laws deter initiation, reduce consumption and promote quitting among existing users.[25]

A study conducted in 31 countries, including developing countries such as Guatemala, Thailand, India, and Georgia, found that women and children who live in the house of a smoker are exposed to significant levels of secondhand smoke, increasing their risk of premature death and disease. Since the implementation of its smoke-free law, Scotland has seen a 17 percent reduction in hospital admissions for acute coronary syndrome, and 67 percent of the decrease was among non-smokers. The 17 percent decrease was significantly greater than the 4 percent decrease over the same time period in England, which at the time was not smoke-free. It was also significantly greater than the average 3 percent annual decline in Scotland in the decade prior to the smoke free law.

India has played a leadership role in global tobacco control. With the growing evidence of harmful and hazardous effects of tobacco, the Government of India enacted various legislations and comprehensive tobacco control measures.[26]

Under the Prevention of Food Adulteration Act (PFA) (Amendment) 1990, statutory warnings regarding harmful health effects were made mandatory for paan masala and chewing tobacco.[27]

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[24] U.S. Department of Health and Human Services. How tobacco smoke causes disease: the biology and behavioral basis for smoking-attributable disease: a report of the Surgeon General. Rockville, MD: Dept. of Health and Human Services, Public Health Service, Office of Surgeon General, 2010.

[25] Supra note 2

[26] Rao V, Chaturvedi P. Tobacco and health in India. Indian J Cancer 2010;47 Suppl 1:3-8

In 1992, under the Drugs and Cosmetics Act 1940 (Amendment), use of tobacco in all dental products was banned.[28]

The Cable Television Networks (Amendment) Act 2000 prohibited tobacco advertising in state controlled electronic media and publications including cable television.[29]

Under the Chairmanship of Shri Amal Datta, the 22nd Committee on Subordinate Legislation in November 1995 recommended to the Ministry of Health to enact legislation to protect non-smokers from second hand smoke. In addition, the committee recommended stronger warnings for tobacco users, stricter regulation of the electronic media and creating mass awareness programmes to warn people about the harms of tobacco. In a way, this Committee's recommendation laid the foundation of developing the existing tobacco control legislation in the country.[30]

Between 1997 and 2001, several litigations e.g K Ramakrishnan and Anr. v. State of Kerala[31] and others and Murli Deora v. Union of India[32] were filed for individual's right to smoke-free air and five states responding with smoke-free and tobacco control legislations, clearly gave the signal for the Government of India to propose a comprehensive law for tobacco control.

The Government enacted the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA), in 2003. The provisions under the act included prohibition of smoking in public places, prohibition of advertisements of tobacco products, prohibition on sale of tobacco products to and by minors (persons below 18 years), ban on sale of tobacco products within 100 yards of all educational institutions and mandatory display of pictorial health warnings on tobacco products packages. The law also mandates testing all tobacco products for their tar and nicotine content.

In 2004, the Government ratified the WHO Framework Convention on Tobacco Control (WHO FCTC), which enlists key strategies for reduction in demand and reduction in supply of tobacco.

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[27] Government of India. Prevention of Food Adulteration Act (PFA) (Amendment) 1990
[28] Government of India. Drugs and Cosmetics Act 1940 (Amendment) 1992.
[29] Government of India. The Cable Television Networks (Amendment) Act 2000
[30] Supra note 21
[31] AIR 1999 Ker 385
[32] 2001 (8) SCC 765

Some of the demand reduction strategies include price and tax measures and non price measures (statutory warnings, comprehensive ban on advertisements, promotion and sponsorship, tobacco product regulation etc). The supply reduction strategies include combating illicit trade, providing alternative livelihood to tobacco farmers and workers and regulating sale to and by minors.[33]

India has been in the forefront of negotiations under various Working Groups of the WHO FCTC and also played a leadership role in bringing region specific c issues e.g smokeless tobacco to the global attention. India has actively contributed to drafting of guidelines as a member of the Inter Government Negotiating Body (INB) to curb the illicit trade of tobacco products. India provided valuable contribution to development of guidelines for Article 9 and 10, 12, 13, 14, 17 & 18 of WHO FCTC.

FCTC Article 8	COTPA Section 4
The FCTC requires the parties to adopt and implement measures to provide for protection from exposure to tobacco smoke in indoor workplaces, public transport and indoor and other appropriate public places. Guidelines to implement Article 8: The Guidelines from the Second Session of COP further draws on the best available evidences and the experience of Parties, besides, identifying the key elements of legislation necessary to effectively protect people from exposure to tobacco smoke.	COTPA prescribes that, "no person shall smoke in any public place". However, the law allows for the exception that hotel with 30 rooms or more and restaurant with seating capacity for 30 people or more or an airport may provide for a smoking area or space. The Government of India on October 2, 2008 notified the rules for effective realization of the objectives of extending protection from SHS as stipulated under the law with more authorized officers to enforce the law and stringent specifications for making a smoking area or space.

Article 8.1 of the Framework Convention on Tobacco Control (FCTC) states that "scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability"

[33] World Health Organization (WHO). Framework Convention on Tobacco Control, 2004.

However, the exemption to the hotels, restaurants and airports to have a smoking area or space opens the room for violation of the smoke-free law and undermines the basic objective of FCTC and COTPA. As recommended by WHO and the Guidelines to Article 8 of FCTC only 100% smoke-free environment is the answer. On the other hand compliance with the law remains a big challenge in the country.[34]

The Rajasthan Voluntary Health Association (RVHA) stated that only 14 per cent of the 139 public places across five cities, which were evaluated for compliance with indoor smoking ban, were found to have specific signage meeting the requirements for size and text under the law.[35]

There has always been a felt need for implementing a comprehensive smoke-free law[36] and considering the high prevalence of oral tobacco use, ban on chewing tobacco should also be considered[37]. A mere prohibition on smoking in public places by the Government might not solve the problem unless efforts to implement the law are made.[38] It is observed that lack of sensitization and awareness of the law's requirements among key stakeholders including officials from the concerned Ministries and State governments encumber implementation of the law.[39]

Though anti-tobacco activism, national policies and political will to an extent is helping bring in anti-tobacco legislation in the larger interest of public health, accountability and ownership for robust and sustainable enforcement measures for implementing tobacco legislation are needed to plug the loopholes in the implementation and enforcement mechanisms. Poor implementation results in failure to achieve the projected health benefits of tobacco control for the population.

Furthermore, multiple law enforcement agencies do not necessarily ensure proper enforcement. Inspection and enforcement with designated roles and responsibilities and dedicated manpower with appropriate penalty entrusted with single agency is needed for sustainable long term impact. Active measures that influences population behavior and empowers civil society also needs consideration to denormalize tobacco use in the general population.

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[34] *Supra note* 5
[35] Infra note 40
[36] JOHN, R. M. & GLANTZ, S. A. 2007. It is time to make smoke free environments work in India. Indian Journal of Medical Research, 125, 599-603.
[37] CHOUDHURY, C. R. & DEY, A. 2004. India should ban chewing tobacco as well as smoking. Bulletin of the World Health Organization, 82, 473-474.
[38] *Supra note* 5
[39] Supra note 28

Methodology

The study will be both doctrinal as well as non-doctrinal. Literature will be collected in the form of books, articles, journals, periodicals and newspapers. So far as the collection of sample is concerned, the data will be collected from the state of Rajasthan.

In order to achieve the above objectives, available studies, scientific and research papers, grey literature, reports and other primary and secondary sources of information were reviewed to inform the status of implementation of the following provisions of COTPA. Internet and web-based research was extensively used to find the relevant materials on the following provisions for this research.

This community based cross-sectional study was designed to assess compliance to the implementation of laws made for tobacco control under COTPA. The study also assessed the knowledge, perceptions and practices towards tobacco use, awareness about harmful effects of smoking on non smokers and knowledge about the COTPA legislation and provisions with-in the same among the tobacco.

Universe of Study

As mentioned earlier, universe of study will be the state of Rajasthan the state of Rajasthan is a big state consisting of 33 districts. It is not possible for the researcher to conduct the study of whole of the state. Therefore, the study will be qualifying the state capital of Rajasthan i.e. Jaipur. The data is collected from the public places (as per Section 2 (l) of COTPA, 2003) of Jaipur.

By contacting experts in this field understand tobacco-related health problem, the specifications and provisions for tobacco control in the tobacco legislation, conduct the community surveys, identify tobacco selling outlets, administer informed consent and undertake vendor interviews with pretested structured questionnaires.

Hypothesis

a. The anti- smoking laws are not sufficient enough and not at par with international standards and policies. There should be strict implementation by government agencies and other authorized persons.
b. People of Rajasthan are not much aware about the affect of smoking and passive smoking and they also having a misconception of non-injuriousness of Beedis than Cigarettes.
c. The present work is presenting a comparative study of anti-smoking laws between India and various other countries.
d. Not only active smokers suffer from smoking but also passive smokers go through at par. The law should be effectively implemented because it's a matter of right to life of passive smokers.
e. The law of banning of public smoking in India is made effective only through people's active involvement.

Significance

Though Rajasthan was one of the leading States to implement the law against public smoking and advertising of tobacco products in 2003, the compliance rate in the State is still low and its policies require more rigorous enforcement with regard to display and sale of tobacco products and "No Smoking" signage at public places.[40]

One of the major goals of any tobacco control effort is to prevent people from starting or experimenting with tobacco. The measures for effective implementations are as following-

- Sensitize, train and empower the law enforcers i.e. Police, Food & Drug Inspectors and other authorized officers.
- Set up flying squads for monitoring, enforcement and compliance.
- Setting up toll-free help line / online reporting system may also be considered.

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[40] The Hindu, Rajasthan needs to go tough on anti-smoking policy, Jaipur, 28 May 2013.

- Establish a mechanism for issue of challan or compounding of offence.
- Give wide publicity to the provisions of the rules; also put it on the official website of the Department.
- create a separate head of account as has been done by Gujarat Government under the department of Health in which the fine collected by various agencies/officers are deposited. This will enable Deptt. of Health to use the fund for tobacco control activities. The head under which the fine is to be credited may be indicated at the bottom of the receipt itself.

Overview of Chapters

The thesis is divided into seven main chapters- first chapter deals with the introduction, chapter II discusses origin and historical development of tobacco and its uses and also briefing about use of beedis , chapter III discuss about the international documents and covenants which support anti smoking laws and also discuss the laws of other countries which strictly prohibited public smoking, Chapter IV determine the laws which prohibits public smoking at national level which also discuss the scenario of various laws in this regard, Chapter V relates to the empirical study which is going to be done in the state of Rajasthan to check out the implementation of laws of anti smoking laws and also discuss the position of other states in this perspective, Chapter VI deals with the effect on the health of non- smokers by reason of smoking in public places in relation to fundamental right to life under Article 21 of Constitution of India and the last chapter deals with the suggestions of effective implementation of anti- smoking laws.

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- http://www.tobaccocontrollaws.org/legislation/
- http://www.secondhandsmokekills.in/

LAW RELATING TO PUBLIC SMOKING IN INDIA: LEGISLATIVE BEHAVIOUR & JUDICIAL TRENDS

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